DEPAI	RTMENT OF H	II ALTI	AND HUMAN SERVICES			PRINTE	D: 10/13/2009
STATEME	EHS FUR MEL NT OF DEFICIENCE	<u> JAHE</u>	& MEDICAID SERVICES			OMB N	M APPROVED O. 0938-0391
	OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING	(≺3) DATE	SURVEY
			09G167	B. WIN	NG		
NAME OF	PROVIDER OR SU	FPLIER		_	CTREET ADORESS OF A STATE OF A ST	08	/28/2009
CAREC	0 10				STREET ADDRESS, CITY, STATE. ZIP COD 1613 TAYLOR STREET, NW WASHINGTON, DC 20011	Æ	
(X4) ID PREFIX	SUMM	A RY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	2507:31	
TAG	REGULATO	" ——	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	IN LEACH CORRECTIVE ACTION 5	SHOULD BE	(X5) COMPLETION DATE
W 000	INITIAL COM	'MENT	s	W 0	000		
	August 27, 2 sampling of the population of of disabilities. This survey of fundamental were based of and one day staff and marked the unusual in 483.420(a)(2) RIGHTS The facility marked the unusual in 483.420(a)(2) RIGHTS The facility marked the client's and behavior treatment, and behavior treatment, and informed of the developments risks of treatment, for included in the the finding included in the the finding included in the the population of the finding included in the the the finding included in the the population of the finding included in the the finding included in the the the population of the finding included in the the the population of the	as corrinces to obse regement admits readily lient is nedically lient is nedically status. I of the RD is and be ent, and be e	ure the rights of all clients. must inform each client, a minor), or legal guardian, condition, developmental s, attendant risks of right to refuse treatment. not met as evidenced by: n, interview and record ed to ensure the rights of sir legal guardian to be s medical condition, ehavioral status, attendant d the right to refuse the three clients (Client #1) e.	W 12	GOVERNMENT OF THE DISTRICT OF DEPARTMENT OF HEALTH HEALTH REGULATION ADMINIST 825 NORTH CAPITOL ST., N.E., 2N WASHINGTON, D.C. 2000 The QMRP will be retrained on obtainformed consent for restrictive measures to the I Committee for review to ensure that individual's rights are protected.	COLUMBIA H TRATION ID FLOOR ID FLOOR IT I	11/23/09
ORATORY	DIRECTOR'S OR	ROVIDEO	ASUPPLIER REPRESENTATIVE'S SIGNAT	URE	TITLE		
last	u H.	1/2/2	111302-	_	_		X6) DATE
deficiency	Statement endin	11 614		<u>_</u>	nivator of Dischility	J. 100-5	Inter!

Any deficiency statement endin I with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficent protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these discussions are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

FORM APPROVED

CENTERS FOR MEDI JARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (2:3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUF 'LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW **CARECO 10** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFINENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATOR Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY W 124 Continued From page 1 W 124 was obtained from Client #1 and/or his legal guardian prio to implementation of his Behavior Support Plan (BSP). Observation of the morning medication administration on August 28, 2009, at 8:06 a.m. revealed Client:#1 received medications including Seroquel 50 r 1g, Ativan 1 mg, and Risperidone 2 mg. Interview with the medication nurse on August 28, 2008 at xxx time, revealed the aforemention ad medications were used in conjunction with a BSP to manage behaviors. Interview with the Qualified Mental Retardation Professional | QIMRP) and review of the client's habilitation re xord on August 28, 2009, at 8:44 a.m. revealed that Client #1 BSP had been revised on July 6, 2009. Continued interview with the QMRP revealed the client did not have the capacity to gire informed consent for the use of medications and habilitation services. The QMRP's statement was verified on the aforemention id date, at 8:56 a.m. through review of Client #1's psychological assessment dated September 8 2008. According to the assessment, Client #1 "currently functions with moderate cognitive and adaptive deficits. He is not able to make independent decisions concerning treatment plan, financial affairs, living arrangement or day placement. He lacks cognitive and academic skills necessary to understand tre implications of such decisions, and therefore cannot give his informed consent in regards to these matters. He likewise cannot execute a dur able power of attorney." According to the QMRP Client #1 had a family member (morner) that had agreed to assist him in decision mak ng. Record verification on August

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FORM APPROVED CENTERS FOR MEDI CARE & MEDICAID SERVICES ()MB NO. 0938-0391 STATEMENT OF DEFICIENCIE (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (. (3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUP *LIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 10 1613 TAYLOR STREET, NW WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEF DIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX (X5) COMPLETION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 124 Continued Fram page 2 W 124 28, 2009 at 1 \pm 36 p.m., revealed a consent form for the prescr bed medication was signed by the aforemention ad family member dated August 20, 2009. Interview with the QMRP revealed that the revised BSP had not been reviewed/approved by the facility's Furnan Rights Committee (HRC). Additionally, the QMRP indicated that Client #1's revised BSP vould be reviewed/approved at the facility's next HRC meeting which was scheduled for September 8, 2009. At the time of the survey, there was no evidence that the facilit 's specially constituted committee ensured that written informed consent had been obtained for the use of Client #1's revised BSP that incorpore and restrictive techniques. W 140 483.420(b)(1) i) CLIENT FINANCES W 140 The facility must establish and maintain a system that assures a full and complete accounting of clients' perso al funds entrusted to the facility on behalf of clier is This STAND#RD is not met as evidenced by: Based on stall interview and record review, the facility failed to ensure a full and accurate accounting of client's financial records for two of five clients reading in the facility. [Clients #2, and The finding in sludes: Interview with the facility 's Qualified Mental Retardation P ofessional (QMRP), Financial Accounts Mai ager (FAM), the House Manager (HM) and reci rd review on 8/28/2009 at approximately 7:00 p.m. revealed the facility could not account for the withdrawal of funds from the

FORM APPROVED CENTERS FOR MEDI DARE & MEDICAID SERVICES <u>()MB NO. 0938-0391</u> STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUF PLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW **CARECO 10** WASHINGTON, DC 20011 SUMM/ RY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEF CHENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATOR Y OR LSC IDENTIFYING INFORMATION) TAG DATE **DEFICIENCY**) W 140 Continued From page 3 W 140 accounts of two of its residents. There was no evidence to substantiate either the reason for the withdrawal or for what the funds were used. The evidences of the deficient practices are presented below: 1. Client #2 's 6/2009 Bank Statement reflect a I. The QMRP will be retrained on the financial 11/23/09 recordkeeping process for the facility, and will withdrawal fc \$350.00 was made on June 8. henceforward be able to produce evidence of how 2009. Furthe record review revealed there were funds were expended upon request, which includes no receipts o. statement(s) outlining what the requesting copies of the receipts submitte I along funds were used for. Interview with the QMRP on with the printed bank statements for authorized August 27, 2/09 at approximately 7:15 p.m. reviewers. revealed, the only documentation provided to her was the copies of the bank statements. There was no additional documentation presented or made availat: e for review. 2. Client #5 s 6/2009 Bank Statement reflect a withdrawal fo \$250.00 was made on June 8. 4/3/01 2. See response to #1 above. 2009. Furthe record review revealed there were no receipts or statement(s) outlining what the funds were used for. Interview with the QMRP on August 27, 2009 at approximately 7:20 p.m. revealed, the only documentation provided to her was the copie's of the bank statements. There was no additi anal documentation presented or made availatile for review. There was no evidence presented or on file at the time of survey to substantiate an effective system of record kee siring and oversight was in place with regards to the management of client's personal funds. W 154 483.420(d)(3) STAFF TREATMENT OF W 154 CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.

DEPARTMENT OF HE ALTH AND HUMAN SERVICES PRINTED: 10/13/2009 CENTERS FOR MEDI: JARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION C(3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUPILIER STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW CARECO 10 WASHINGTON, DC 20011 (X4) ID PREFIX SUMMA LY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFI HENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROPRIATE REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY W 154 Continued Fr. m page 4 W 154 This STAND/ RD is not met as evidenced by: Based on stall interview and record review, the facility failed to ensure the investigation of a client's emergerat care as required by this section for one (1) of hree (3) randomly sampled clients. (Client #1) The findings include: 1. Staff inter riew and record review on August 1. The QMRP will ensure that copies of completed 28, 2009 at a proximately 5:15 p.m. revealed an incident investigations are maintained in the clients' 11/23/09 incident repor dated March 19, 2009 was records in the facility. All incidents are completed to iddress Client #1's "coughing, investigated by the Incident Management choking, and equirgitating ". The incident report Coordinator and the QMRP, per facility pelicy. further accounts this client was taken to ER for treatment. Ft rther interview with the facility's Qualified Meri al Retardation Professional (QMRP) on A igust 28, 2009 at approximately 5:35 p.m. revoaled there was no evidence that an investigation vas initiated or completed to address this is cident report. 2. Staff inter riew and record review on August 28, 2009 at ar proximately 5:45 p.m. revealed an 2. See response to #1 above. incident repor July 12, 2009 detailed Client #1 eloped from tille residential facility and local law enforcement I ad to be involved in the missing person 's search. Interview with Licensed Practical Nurs (LPN) on August 28, 2009at 6:32 p.m. revealed this client was missing for three days from Sur day (7/12/2009) to Tuesday afternoon (7/1 1/2009). The nurse further revealed they ound out later that he was being held and under care at the DC Department of Mental Health 's Comprehensive Psychiatric

Emergency P ogram (CPEP) as a "John Doe". He was released on the evening of July 14, 2009 and transported back to the residential facility.

DEPARTMENT OF HE ALTH AND HUMAN SERVICES PRINTED: 10/13/2009 FORM APPROVED CENTERS FOR MEDI: ARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE! (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (23) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUP! LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW **CARECO 10** WASHINGTON, DC 20011 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFI HENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 154 Continued Fr. m page 5 W 154 Further interv av/ revealed there was no evidence at the time of survey that an investigation was initiated or completed to address this incident. W 159 483.430(a) QIJALIFIED MENTAL W 159 RETARDATION PROFESSIONAL Each client's a ctive treatment program must be integrated, coordinated and monitored by a qualified men al retardation professional. This STANDARD is not met as evidenced by: Based on stat interview and record review, the facility's Quali led Mental Retardation Professional (2MRP) failed to ensure the coordination, nunitoring, and implementation of a client's habilit tion and planning for four of five clients residin; in the facility. [Clients #1, #2, #3, and #51 The finding includes: Interview with the facility's QMRP on 1. The QMR 3 failed to ensure a full and See response to W140. 11/23/09 accurate accc unting of all financial records. [See W1401 2. The QMR 3 failed to ensure investigations 2. See response to W154. were complet: d to address incidences of clients 11/23/09 being provide emergent care. [See W154] 3. The Director of Disability Services will meet with the psychiatrists us Seton House, which is

FORM CMS-2567(02-99) Previous \ arts one Obsolete

W2121

3. The QMR 3 failed to ensure Clients received

a comprehent ive psychiatric assessment prior to

being prescrit ad psychotropic medications. [See

4. The QMR 's failed to ensure behavior support plans (BSP) had been reviewed and approved by

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where clients receive their care. The DoD.3 will

request that the Seton House psychiatrists provide

comprehensive psychiatric assessments that can be

updated as needed, prior to psychotropic

medications being prescribed.

4. See response to W124,

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DEPAR	RTMENT OF HE	A-TH	AND HUMAN SERVICES				PRINTED	0: 10/13/2009
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W 159	Continued Fr	ıtrı pa	ge 6	W	15			
	the Human R implementation	ghts (n. [Se	Committee (HRC) prior to se W262]					
W 214	informed conguardian was implementatik (BSP). [See V 483.440(c)(3)	ent fro obtain n of a /263] iliji IN! onsive	ed to ensure that written om either client or legal ned prior to the Behavior Support Plan DIVIDUAL PROGRAM PLAN functional assessment must	W 2	214	The Director of Disability Services will in	net with	
	This STANDA Based on obserview, the factories clients (that was presented in the control of the	ent's s nagen RID is ervatio ility fa client a ribed	Decific developmental and			the Psychiatry Department at Seton Hous the clinic where all clients served receive psychiatric care. The DoDS will continue up with the psychiatrists to ensure that a comprehensive evaluation is completed for person served.	e which is their to follow	11/23/04
	7:48 a.m., rev and 15 mg by mould on the aforem and the second se	the ad Augus aled (h Intentions press	dministration of the morning at 28, 2009, at approximately client #3 received Buspirone erview with the nursing staffed date revealed that the cribed for anxiety and that he					
	26, 2009, at app physician's on a to the physician Risperidone 3 n twice a day. Th	proximer (dat 's ordang ng wa e phys	medical record on August nately 8:44 a.m., revealed a red August 2009). According er Buspirone 15 mg and s prescribed for Client #3 sician's order also revealed osis was "psychosis."					

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FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO, 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (13) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUP. LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW **CARECO 10** WASHINGTON, DC 20011 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFI HENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOUL) BE TAG REGULATOR / OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY W 214 Continued Frr m page 7 W 214 Further review of the record revealed that the client's psychotropic medications was incorporated 1 a Behavior Support Plan dated February 14, ::009, to address behaviors associated with physical aggression, self-injurious behavior, and socially inappropriate self-stimulatory behaviors. Continued review of Client #3's record revealed a medical consilit dated May 14, 2009. The consult indica ed that the purpose of the visit was "psychiatric," Lowever, the consult did not reflect any evidence of a comprehensive psychiatric evaluation, all lough the findings indicated "patient is stal le with his explosive behavior" and the recommer dations was to continue current medications. At the time of he survey, the facility failed to provide documented evidence that Client #3 had a comprehent ive psychiatric evaluation that identified his current diagnosis. W 262 483.440(f)(3)() PROGRAM MONITORING & W 262 CHANGE The committe : should review, approve, and 11/23/09 See response to W124. monitor individual programs designed to manage inappropriate sehavior and other programs that, in the opinion of the committee, involve risks to client protecticn and rights. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a behavior support plan (3SP) had been reviewed and approved by their Human Rights Committee (HRC) for one of the three clients (Clients #1)

included in the sample.

F'RINTED: 10/13/2009

FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES MB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION () 3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G167 08/28/2009 NAME OF PROVIDER OR SUP! LIER STREET ADDRESS, CITY. STATE, ZIP CODE 1613 TAYLOR STREET, NW **CARECO 10** WASHINGTON, DC 20011 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID ΙĎ PROVIDER'S PLAN OF CORRECTION (EACH DEFI JENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) (EACH CORRECTIVE ACTION SHOULD) BE CROSS-REFERENCED TO THE APPROFRIATE PREFIX REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG DATE DEFICIENCY) W 262 Continued From page 8 W 262 The finding in :ludes: Observation c. I the morning medication administration on September 28, 2009, at 8:06 a.m. revealed Client #1 received medications including Serc quel 50 mg, Ativan 1 mg, and Risperidone 2 mg. Interview with the medication nurse on Sepi ember 29, 2009, revealed the aforemention« d medications were used in conjunction with a BSP to manage behaviors. Interview with the Qualified Mental Retardation Professional (2MRP) and review of the client's habilitation record on August 28, 2009, at 8:44 a.m. revealed that Client #1's BSP had been revised on Ju / 6, 2009. Interview with the QMRP acknowleded that the revised BSP | acl not been reviewed/approved by the facility's H ıman Rights Committee (HRC). Additionally, ti e QMRP indicated that Client #1's revised BSP v ould be reviewed and approved at the facility's next HRC meeting which was scheduled for September 8, 2009. At the time of he survey, there was no evidence that the facility s specially constituted committee ensured that Client #1's revised BSP that incorporated restrictive techniques had been reviewed and approved by it's HRC. W 263 483.440(f)(3)() PROGRAM MONITORING & W 263 CHANGE 11/23/09 See response to W124. The committees should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or lega guardian.

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Event ID: MM5511

Facility ID: 09G167

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DEPAR	TMENT OF HE	ALTH	AND HUMAN SERVICES				PRINTE	D: 10/13/200	19
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W 263	Continued Fr	ını pa	ge 9	W 2	26				-
	facility's specensure that reafter written cof the three cosample.	rv ew ally-co strictiv onsen ents (s not met as evidenced by: and record review, the instituted committee failed to re programs was used only ts had been obtained, for one Client #1) included in the						
•	Consent was 🗀	ed to obtaine	ensure that written informed and from Cilent #1 and/or legal implementation of his					-	
	the entrance of medication with manage the collination with the collination with the collination of the coll	DIMRP onfered sused ent's to tion re ent #1 ng to the edical	valified Mental Retardation) on August 28, 2009, during noce revealed Client #1's I in conjunction with a BSP to behaviors. Review of the cord on August 28, 2009, had a BSP dated July 6, he BSP, Client #1 received tions for Intermittent //o alcohol abuse.						
	giving informed medications at to the QMRP	l Clier conse d habi lient#	with the QMRP and record at #1 was not capable of ent for the use of ilitation services. According 1 had a family member eed to assist him in decision						
	iachity's speci ill	here v V cons	vey, the QMRP vas no evidence that the stituted committee ensured consent had been obtained						

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STATEMENT OF DEFICIENCIE: AND PLAN OF CORRECTION		Thurst was a part of the	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		() 3) DATE SURVEY COMPLETED	
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1 000	INITIAL COM	MENTS		1 000				
	8/27/09 to 8/2 residents was individuals with The findings cobservations program, intermanagement.	survey was conducted from 3/09. A random sampling selected from a population varying degrees of disaling this survey were based of the group home and on view with direct care staff and a review of the hability records including the unuse.	of three on of five cilities. on e day and tation and					
1 090	3504.1 HOUS	DUS EKEEPING				İ		
	maintained in and sanitary r	d exterior of each GHMR a safe, clean, orderly, attra anner and be free of of dirt, rubbish, and object	active,					
	Based on obs Group Home (GHMRP) faili- maintenance of five resider	not met as evidenced by envation and staff interview or the Mentally Retarded I id to ensure the proper of the facility's environments [Residents #1, #2, #3, # the facility as identified be actual.	v, the Person t for five 4. and					
	During the endaged	ironmental inspection on a proximately 5:30 p.m., the ces were identified:	August following		<u>.</u> .		·	
	bedrooms and	eas along the walls in the hallway leading to the bed and plastered.	drooms		The Director of Operations will direct maintenance to plaster/paint the hallway		11/23/09	
Thas	tion Administration	Moups.			TITLE	×	6) DATE	
STATE FORM		ROVIDER/SUPPLIER REPRESENT	TATIVE'S SIGNA		Director of Disability	4 Service	5 10/23/	

FRINTED: 10/13/2009 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION NG	(X3) DATE (COMPL	(X3) DATE SURVEY COMPLETED				
	HFD03-0160			B. WING		08/28/2009			
NAME OF P	ROVIDER OR SUPF	JER	STREET AL	DRESS, CITY	STATE, ZIP CODE	1 001	LGIZOUS		
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1 090	Continued From	n page 1		1 090					
	the hall bath. 3. A broken backside of the bedroom. 4. The close was broken.	ely loose toilet seat was for owel rack was observed on cloor leading into Reside door in Resident #5's bed	on the ent #5's droom		2. The Director of Operations will dire maintenance to repair the toilet. 3. The Director of Operations will direct maintenance to replace the broken town. 4. The Director of Operations will direct maintenance to repair or replace the closes. 5. The Director of Operations will direct maintenance to operations will direct maintenance.	et rick.	11/23/04 11/23/09 11/23/09		
	5. Peeling plain't was observed around the lig fixtures in the living room.		the light		maintenance to scrape and repaint the a peeling paint was observed.		11/23/09		
1 092	3504.3 HOUS	EK:EEPING		1092	•	:			
	and vermin.	shall be free of insects, ro			The Residential Director will inspect the least monthly to ensure there is no evide vermin or insect infestation. The spider be removed.	nce of	11/23/09		
	Based on obsertacility failed to five of five res	not met as evidenced by rvation and staff interview ensure a bug free environations residing in the faciliter, #3, #4, and #5]	, the nment for						
	The finding incl	ludes:							
	During the environmental inspection on August 27, 2009 at an proximately 5:55 p.m., a spider's nest was observed on the light fixture for the from porch.		pider's						
	QMRP at the sarevealed the sare	he GHMRP's house mana arne time as the observat icler's nest should not be removed the nest immed	on there						
l 183	3508.4 ADMIN	STRATIVE SUPPORT	,	I 183	 				
ealth Regula	ation Administratic								

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STATEMENT OF DEFICIENCIE: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	A. BUILDI		() 3) DATE COMP	() 3) DATE SURVEY COMPLETED 08/28/2009	
-		HFD03-0160		B. WING	08/			
					STATE, ZIP CODE			
CARECO	10		WASHING	LOR STRE TON, DC	ET, NW 20011			
(X4) ID PREFIX TAG	(EACH DEFI	LY STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY CIR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
l 183	Each GHMRF who meets the shall manage approved poli. This Statute is Based on statifacility's Quality Professional (coordination, resident's hab	shall have a Residence E requirements of § 3509. The GHMRP in accordance ites and this chapter. Inot met as evidenced by interview and record revised Mental Retardation QMRP) failed to ensure the nonitoring, and implement litation and planning for folling in the facility. [Reside]	and who e with : ew, the eation of a pur of five	I 183				
	accurate accr	Pailed to ensure a full an uniting of all financial recor and Report Citation W140	ds. (See l		1. See response to federal deficience	W140.	11/23/09	
	were complet- residents beir	□ failed to ensure investigated to address incidences of provided emergent care, arroy Report Citation W154	f See	• • .	2. See response to federal deficience	v W1; 4.	11/23/09	
	received a com assessment proposed of the contraction of the contracti	Priailed to ensure Residen rprehensive psychiatric ricr to being prescribed nedications. [See Federal port Citation W214]	ts	-	3. See response to federal deficiency	W214.	11/23/09	
Ì	4. The QMR is failed to ensure behavior support plans (BSP) had been reviewed and approved by the Human Rights Committee (HRC) prior to implementation. [See Federal Deficiency Report Citation W26.]				4. See response to federal deficiency	W2(-2.	11/23/09	
}	informed con: e guardian was :	Priailed to ensure that writtent from either resident or obtained prior to the	en legal	į	5. See response to federal deficiency	W263.	11/23/09	
	tion Administration		<u> </u>					
TATE FORM	l		68	130 M	M5511	lf continu	ation sheet 3 of 7	

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STATEMENT OF DEFICIENCIE 3 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD03-0160 08/28/2009 NAME OF PROVIDER OR SUP 'LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1613 TAYLOR STREET, NW **CARECO 10** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PREFIX (EACH DEF DENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATOR / OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY 1183 Continued From page 3 1183 implementatic n of a Behavior Support Plan (BSP). [See I ederal Deficiency Report Citation W2631 1375 3519.6 EMEF GENCIES 1375 Each GHMRF shall document each emergency and enter the follow-up actions into the resident ' s permanent record, which shall be made available for review by authorized individuals. This Statute is not met as evidenced by: Based on stall interview and record review, the facility failed to ensure the investigation of a resident's em injent care as required by this section for on a (1) of three (3) randomly sampled residents. (R :s.dent #1) The findings i sclude: Staff interview and record review on August 28, 2009 at a proximately 5:15 p.m. revealed an 1. See response to federal deficiency WI 54. incident repor dated March 19, 2009 was 11/23/04 completed to address Resident #1's " coughing, choking, and equirgitating ". The incident report further accounts this resident was taken to ER for further treatm ant. Further interview with the facility's Qual. led Mental Retardation Professional (QMRP) on August 28, 2009 at approximately 5 35 p.m. revealed there was no evidence that an investigation was initiated or completed to address this incident report. 2. Staff inter /iew and record review on August 28, 2009 at approximately 5:45 p.m. revealed an 2. See response to federal deficiency W1: 4. 11/23/69 incident repor July 12, 2009 detailed Resident #1 eloped from the residential facility and local law enforcement : ad to be involved in the missing person 's search. Interview with Licensed Practical Nurs a (LPN) on August 28, 2009 at 6:32

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	ATEMENT OF DEFICIENCIE. D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0160		R/CLIA MBER:	(X2) MULT A. BUILDII B. WING		(2.3) DATE COMP	SURVEY LETED	
NAME OF P	ROVIDER OR SUPILIER		CTDEET ADD			08/	08/28/2009	
CARECO		`		LOR STRE	STATE, ZIP CODE ET, NW 20011			
(X4) ID PREFIX TAG	(EACH DEFI ;IEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY ILSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOUL) BE IE APPROFRIATE	(X5) COMPLETS DAYE	
	p.m. revealed this days from Sunday afternoon (7/: 4/2) revealed they four held and under call Mental Health 's Emergency Program He was released and transported by Further interview initiated or complete.	s resident was missing (7/12/2009) to Tuesd (009). The nurse further hid out later that he was are at the DC Department (CPEP) as a "Johon the evening of July ack to the residential frevealed there was no vey that an investigation at the deduction of the december of the residential frevealed there was no vey that an investigation at the deduction of the december of the december of the deduction of the december	ay er s being ent of iatric in Doe " 14, 2009 acility. evidence	1 375				
	that the rights of n protected in a cor	TS RIGHTS idence director shall elesidents are observed dance with D.C. Law 2 rapplicable District and	and -137, this	1 500	See response to federal deficienc	 y W124.	11/23/09	
	Based on observareview, the G IMR residents' rights in Chapter 13 of the D.C. Law 2-1:7, D that governs the carmental retard ition	t met as evidenced by: tions, interviews and re P failed to observe and accordance with Title D.C. Code (formerly ca b.C. Code, Title 6, Chap are and rights of person for one of the three re- ided in the sample.	ecord d protect 7, alled oter 19)					
	was obtained from	ensure that informed Resident #1 and/or his oplementation of his Bo	s legal					
1	Observation af the	momina medication	1					

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN			():3) DATE SURVEY COMPLETED			
	HFD03-0160			B. WING_	B. WING 08/28/20						
NAME OF PROVIDER OR SUPI LIER STREET AL			STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 0012					
CARECO	10			1613 TAY WASHING	LOR STREETON, DC 2	ET, NW 0011					
(X4) ID PREFIX TAG	(EACH DEFI	JENCY	(Y STATEMENT OF DEFICIENCIES JENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)			NCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOLL				DUL 2 BE	(X5) COMPLETE DATE
	a.m. revealed including Service Risperidone 2 nurse on Sep aforemention conjunction with professional (habilitation rea.m. revealed revised on Juthe QMRP recapacity to gimedications a QMRP's state aforemention of Resident # September 8, assessment, moderate cognitive and therefore or concerning the arrangements cognitive and therefore regards to the execute a duration making 28, 2009 at 115 for the prescriptore aforemention and 2009. Intervivorevised BSP 1 arrangement aforemention and 2009. Intervivorevised BSP 1 arrangemention and 2009. Intervivorevis	on S Residently Ing. ernbed me the question of the post of the pos	eptember 28, 2009, a dent #1 received med 50 mg, Ativan 1 mg, Interview with the mean 29, 2009, revealed dications were used 3SP to manage behalful alified mental retard 2) and review of the continued interview with BSP had 309. Continued interview the client did not have med consent for the bilitation services. To was verified on on the at 8:56 a.m. through chological assessme According to the ent #1 "currently function and adaptive deficits dependent decisions at plan, financial affairly placement. He lack mic skills necessary ications of such decivit give his informed cutters. He likewise calcutes. He likewise calcutes are dication was signed at had agreed to assecord verification on M, revealed a conservedication was signed to been reviewed/appressing member dated Au the QMRP revealed to been reviewed/appressions of such decivation was signed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to be a secord verification on the QMRP revealed to t	dications and edication the edication the in viors. lation client's at 8:44 been view with ve the e use of he e gh review ent dated tions with. He is irs, living as to sions, onsent in innot a family ist him in August at form I by the gust 20, I that the oved by	1500						
	tion Administrati:		Rights Committee (H	IKC).							

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STATEMENT OF DEFICIENCIE: AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILDING			C:3) DATE SURVEY COMPLETED			
			HFD03-0160		B. WING_	<u> </u>	08/2	8/2009
NAME OF PROVIDER OR SUP 'UER STREET ADD					DRESS, CITY,	STATE, ZIP CODE		
CARECO) 10 ————————————————————————————————————			1613 TAY WASHING	LOR STREET	et, NW 0011		
(X4) ID PREFIX TAG	(EACH DEF	HENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (ÉACH CORRECTIVE ACTIOI CROSS-REFERÊNCED TO THE DEFICIENCY)	N SHOULD BE E APPROLIRIATE	(X5) COMPLETE DATE
1 500	Continued Fr	яті ра	ge 6	•	1 500	•		
	#1's revised in the facility's no scheduled for	SP w ext Hi Septe	MRP indicated that R rould be reviewed/ap RC meeting which was ember 8, 2009.	proved at				
	that the facilit /'s specially constituted committee ensured that Resident #1's revised BSP that incorporated restrictive techniques, had been reviewed/app roved by it's HRC.							
	The QMRP a	sknov	/ledged this finding.					
			·					
								ļ.
İ								
i								
doalth Degui	ation Administra d					<u> </u>		